Provider Insider

Alabama Medicaid Bulletin — **September 2003**

The checkwrite schedule is as follows:

09/05/03 09/12/03 09/26/03 10/10/03 10/24/03

As always, the release of direct deposits and checks depends on the availability of funds.

Medicaid HIPAA Implementation Date Postponed

The original target date of September 27, 2003 for Medicaid HIPAA implementation has been postponed. You will receive notification at least three (3) weeks in advance of the new implementation date. You must continue to use current claim submission methods until the new implementation date. Claims or other transactions submitted in the new HIPAA compliant formats will not be accepted until the implementation of the HIPAA compliant system.

In addition, the statewide HIPAA workshops will continue as scheduled. If you have any questions, please contact your EDS Provider Representatives or the EDS Provider Assistance Center at (800) 688-7989. You may also check the Medicaid HIPAA Website at www.medicaid.state.al.us/HIPAA/index.htm. Click on the HIPAA News button for updates.

Here are some other important points to remember about HIPAA :

- **Local Code Changes**: Alabama Medicaid local codes will be accepted for dates of service through December 31, 2003 and nationally assigned codes (CPT/HCPCS) will be accepted for dates of service effective January 1, 2004.
- **Provider Manual Updates** : Providers will be mailed a CD-ROM in September 2003 that contains the updates made to the provider manual for HIPAA. When the CD is received in your office, please load it onto your computer.
- **Provider Electronic Solutions (PES) Software**: The EDS Provider Electronic Solutions Software will be mailed to all providers prior to implementation.
- **HIPAA Code Set Regulations**: The HIPAA Code Set Regulations establish a uniform standard of data elements used to document reasons why patients are seen and the procedures performed during health care encounters. HIPAA specified code sets to be used are:

  1) Diagnosis Codes - ICD 9

  2) Procedure Codes - CPT, CDT-4, and HCPCS - Level II

In This Issue…

Pass It On!

Everyone needs to know the latest about Medicaid. Be sure to route this to:

- ❒ *Office Manager*
- ❒ *Billing Dept.*
- ❒ *Medical/Clinical Professionals*
- ❒ *Other _____*

Comprehensive Examinations (D0150)

This code should not be billed merely because it is the initial exam for a recipient. It may require taking and interpretation of additional diagnostic procedures such as radiographs, etc. This code has very specific requirements listed in the CDT-4 Manual:

Comprehensive exam is a thorough evaluation and recording of:

Medical and Dental History
Both intramural and extraoral soft tissues
Dental caries
Missing or unerupted teeth
Existing restorations
Occlusal relationships
Periodontal conditions
(including complete periodontal charting)
Hard and soft tissue anomalies
Oral cancer screening

Documentation in the dental record of each of the above findings for hard and soft tissues is required even if each finding is normal.

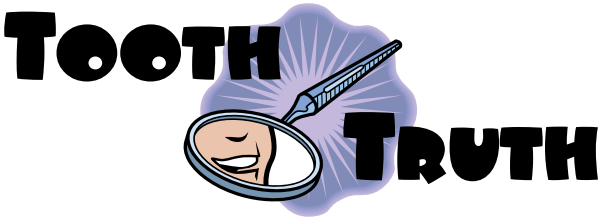
Space Maintainers (D1510, D1515, D1520, D1525)

New policy that went into effect July 1, 2003:

- Requires tooth letter(s) that are prematurely lost be listed on the claim form and the prior authorization form
- Not covered for premature loss of primary incisors or used as "pedo bridge"
- Not covered if maintainer placed greater than 90 days after the premature loss of primary tooth
- Limited to one per recipient's lifetime for a given space to be maintained

Incomplete Procedures

For multiple appointment procedures, payment will be made to the provider that started the procedure. Documentation must exist that attempts were made to complete the procedure (i.e. phone calls, letters) and be supported in the medical record. Billing should only occur after documentation of failed attempts. If the recipient is treated by a subsequent provider for the same procedure, same tooth, the services are considered non-covered. If in doubt as to whether a started procedure has already been paid in Medicaid Claims History, contact the Medicaid Dental Program before initiating treatment.



HIPAA Codes for Cavity Designation

To be consistent with the American Dental Association as mandated by HIPAA, Supernumerary Teeth and Oral Cavity Designation will be coded as follows:

A supernumerary tooth for Permanent Dentition (Tooth numbers 01-32) will have 50 added to its tooth number. Therefore if a patient has an extra tooth number 30 it should be coded as tooth number '80' (30 + 50 = 80). Valid numbers will be 51 through 82. Primary Dentition (Tooth numbers "A" through "T") will place an 'S' after the tooth code. If a patient had an extra 'A' tooth, it will be coded 'AS'. Valid numbers will be 'AS' through 'TS'.

The following codes must be used for Oral Cavity Designation:

Code	Designation
10	Upper Right Quadrant
20	Upper Left Quadrant
30	Lower Left Quadrant
40	Lower Right Quadrant
01	Upper Arch
02	Lower Arch
00	Full Mouth

These new codes will be effective as of September 27, 2003 whether you send paper or electronic claims.

Medicaid Clarifies Extraction Procedures

Only "Extraction, erupted tooth or exposed root" (D7140) is authorized for extraction of primary teeth. Exception: Ankylosed or impacted primary teeth may be submitted by report with radiographs to the Medicaid Agency Dental Program.

Partial Bony Impactions and Soft Tissue Impactions

There appears to be some confusion with some providers as to what constitutes partial bony or soft tissue impaction. The ADA in their CDT-4 Manual describes the criteria for each:

Partial Bony Impactions (D7320) exist when part of the crown is covered by bone and requires a mucoperiosteal flap elevation and bone removal.

Soft Tissue Impactions (D7220) exist when the occlusal surface of the tooth is covered by soft tissue and requires a mucoperiosteal flap elevation.

Documentation Required:

Documentation regarding the type of extraction, flap, and any sutures placed are required in the dental record. In addition, radiographic findings consistent with the above descriptions must be present in the record. Upon request, providers may be required to provide Medicaid documentation to support the billing of these codes.

Billing Procedures for Crowns, Buildups, Post and Cores for Ages 15 and Over

Crowns, Buildups and Post & Cores are only covered on eligible recipients age 15 or older meeting criteria. These procedures are only authorized after successful completion of endodontic therapy. The following are just some reasons that the above procedures may not be authorized:

- partially obturated or non-obturated canals
- missed canals
- separated instruments in canals
- chronic apical rarefactions associated with failing endodontic treatment
- persistent pain, swelling, or abscess from a completed endodontically treated tooth
- chronic periodontal pain or pocketing attributed to endodontic therapy
- vertical root fractures resulting in periodontal pocketing and/or bone loss
- compromised periodontal conditions associated with the tooth to be crowned
- extensive caries resulting in non-restorability
- extensive caries requiring a crown lengthening procedure for restorability

If there is any doubt as to the prognosis of a tooth being treated with these procedures, consideration for placing a temporary crown should be considered. This will allow protection of the tooth, while providing time to evaluate the condition. Stainless steel crowns remain covered regardless of age.

Attention Eye Care Providers

Classic Optical Laboratories, Inc. is now available on-line for internet ordering. All internet sites are secure. Please remember that orders canot be processed without all pertinent information. Classic will provide help services and a follow-up letter to all eye care providers. In addition, Classic will telephone providers for assistance. The website address is www.classicoptical.com.

REMINDER

Provider Enrollment

Services provided must be billed under the rendering "performing" provider's number and not under another provider's number. All providers who must enroll in order to provide services to Alabama Medicaid recipients must bill for services provided using their own provider number and cannot submit claims under another provider's number pending enrollment. Claims must be held for submission until a valid Alabama Medicaid provider number is obtained. It is important that providers submit the provider enrollment application as soon as possible for new enrollments since the effective date is the first day of the month in which the completed application is submitted to EDS. This applies to obtaining provider numbers for additional practice locations as well. Providers will not be reimbursed for claims submitted without a valid provider number. Please refer to Chapter 2, Becoming a Medicaid Provider, and Chapter 7, Understanding Your Rights and Responsibility as a Provider, in the Alabama Medicaid Provider Manual for additional information.

Recipient Education a Priority

Recipient education continues to be a priority. When all attempts to educate the non compliant Patient 1st recipient by the PMP and Targeted Case Management for the Medically at Risk have failed, you may notify Medicaid for further attempts to educate the recipient.

New on Medicaid's website is Form 379, Patient 1st Request For Patient Education. Form 379 can be downloaded, completed, and faxed to (334) 353-3856 or emailed to khassett@medicaid.state.al.us.

Change Forms Available On Internet

Instead of using snail mail or fax to change a recipient's PMP you may now send Patient 1st Recipient Change Forms via the internet. Simply go to www.medicaid.state.us.al; from the Home Page click on either Forms or Site Map; scroll down to Miscellaneous; click on Form 349 - How to Change Your Patient 1st Personal Doctor; click on e-mail form; complete the Form and click on Submit.

The information is automatically sent to Georgette Harvest, Associate Director in Customer Service, and the request for change is initiated. If the change request meets all criteria i.e. age, county, caseload the change request is sent to the appropriate area for completion.

However, completing and submitting Form 349 via the internet does not mean the change requested is instantaneously and automatically made. If you have questions, call or email Georgette Harvest at (334) 242-5019 or gharvest@medicaid.state.al.us.

Procedure/Diagnosis Code Restrictions

To ensure that claims are being paid for medically necessary and medically appropriate procedures, Medicaid has adopted Medicare's LMRP process. LMRP is the acronym for Local Medical Review Policy. Medicare has established such policies for both Part A (hospital) and Part B (physician) claims. So that efforts are not duplicated or contradictory, Medicaid will be adopting certain LMRPs for claims editing/payment. Please refer to Medicaid's Website - What's New for details on this process and what codes are affected.

www.medicaid.state.al.us

New Procedure Code for Darbepoetin Alfa and Pegfilgrastim

Medicaid covers physician drugs when billed by a physician using the new list of approved HCPCS and CPT codes. In accordance with HCPCS changes, procedure code S0112 (Darbepoetin Alfa, 1 mcg) was discontinued effective April 1, 2003. Procedure Code J0880 (Darbepoetin Alfa, 5 mcg) effective start date is January 1, 2003. Please inform billing staff to use procedure code J0880 for the appropriate date of service (as noted above) when filing claims for Darbepoetin Alfa. **NOTE**: Billing staff should note the dosage change as well when calculating units.

For dates of service, effective January 1, 2003 and after, the appropriate procedure code to utilize for Pegfilgrastim 6 mg is S0135. Please inform billing staff to use procedure code S0135 for the appropriate date of service.

October is LEAD Month

Remember it is essential to screen all children at ages 12 and 24 months for lead poisoning. Report ALL levels > 10ug/dL to the Health Department using the ADPH-FHS-135 form. Forms and educational materials are available at the Health Departments website www.adph.org/aclppp. For any questions, please call 1-334-206-2966. Keep Alabama's kids lead free!

Visit Alabama Medicaid

ONLINE

www.medicaid.state.al.us

Universal Newborn Hearing Screening Update

Alabama has come a long way and deserves a pat on the back! According to the Deafness Research Foundation, National Campaign for Hearing Health, data collected by the National Center for Hearing Assessment and Management Utah State University (NCHAM), Alabama received an excellent State Report Card as of May 2003! An excellent score means that 90-100% of babies are being screened. Babies screened in Alabama as of May 2002 was 75% and babies screened in Alabama as of May 2003 is 90%. That's a 20% increase in one year and is very impressive.

According to the American Academy of Pediatrics (AAP), released July 8, 2003, "Considering that hearing loss is our nation's number one birth defect and a reliable hearing test costs as little as $20, it is imperative that States continue to receive federal funds for this important healthcare program," said Susan Greco, Executive Director of the Deafness Research Foundation…"Now that most babies are being screened, we must make sure that primary care physicians become better informed about what they can do to help infants with hearing loss identified in this important process," said Louis Z. Cooper, M.D., immediate past President of the AAP. "It is a great accomplishment that almost all babies are now being screened for hearing loss, but we still have lots of work to do to ensure babies referred from screening get timely and appropriate diagnostic and educational services," said Karl While, Ph.D., Director of the National Center for Hearing Assessment and Management at Utah State.

The Alabama Department of Public Health has purchased two additional pieces of newborn hearing screening equipment, one to perform ABRs and the other to perform AOEs. The purpose of the additional equipment is for loans to hospitals as necessary. To obtain additional information, please contact Melissa Tucker at melissatucker@adph.state.al.us by e-mail or (334) 206-2944 by phone.

ImmPRINT Is On The Way

ImmPRINT is on the way! Immunization registries are confidential, population-based, computerized information systems that contain information about immunizations and children. ImmPRINT is exempt from HIPAA. Benefits for Healthcare Providers are:

- Consolidate immunizations from all providers into one record
- Provide a reliable immunization history
- Provide definitive information on immunizations due or overdue
- Provide current recommendations and information on new vaccines
- Produce reminders and recalls for immunizations due or overdue
- Complete day-care, school, and camp immunization record requirements
- Reduce a provider's paperwork
- Facilitate introduction of new vaccines or changes in the vaccine schedule
- Help manage vaccine inventories
- Generate immunization reports for efficient healthcare management
- Reinforce the concept of the medical home

If you are interested in pilot testing this program, please contact the Immunization Division at the Alabama Department of Public Health at 1-800-469-4599, Denise Strickland.

Procedure Codes For DME

Effective February 1, 2003, Alabama Medicaid began coverage of the manual wheelchair base and the hospital bed to accommodate weight capacities of 600 pounds or greater. The manual wheelchair base is covered using procedure code K0009 and the hospital bed is covered using procedure code K0550. The wheelchair component or accessory not otherwise specified for the wheelchair is covered using procedure code K0108 (an already existing code).

We use the established prior authorization criteria for the other manual wheelchair base, the hospital bed and the wheelchair component or accessory not otherwise specified. We also, require weight, width, and depth specifications for these items. Medicaid requires the provider to submit available MSRPS from three manufacturers for the items.

Effective June 20, 2003, Medicaid began coverage of motorized wheelchairs (K0010, K0011, K0012, K0014) for adults 21 years of age and above. To qualify for motorized wheelchairs the patient must meet Alabama Medicaid's established coverage criteria and all necessary medical documentation must be submitted.

Effective July 1, 2003, the Alabama Medicaid Agency began coverage of heavy-duty walkers using procedure code E0149 and extra wide/heavy duty commode chairs using procedure code E0168. These items are covered for Medicaid recipients who meet the coverage criteria and weigh 300 pounds and above. We use the established prior authorization process for these items but add weight specifications for the walkers and weight, depth and width specifications for the extra wide/heavy duty commode chairs.

Effective July 1, 2003, Medicaid began coverage of the male external catheters with or without adhesive, with or without anti-reflux device (A4347) for adult males 21 years of age and above; limited to thirty per month for adults.

Effective October 1, 2003, Medicaid DME (durable medical equipment) providers will no longer be able to bill for procedure codes J7618 and J7619 (albuterol inhalation solutions) through the durable medical equipment program. These inhalation solutions must be billed through the pharmacy program using NDC codes effective October1, 2003.

Effective October 1, 2003, Medicaid will no longer cover the Lap Top Ventilator System using procedure code E1399. The LTV System will be covered using procedure code E0454 (R). It is the provider's responsibility to supply Medicaid with the necessary medical documentation justifying the need for the LTV System.

Effective October 1, 2003, Medicaid will no longer cover the Volume Ventilator stationary or portable, with backup rate feature, used with non-invasive interface using procedure code E1399. This Ventilator will be covered using procedure code E0461(R).

Special Information for DME Providers

Medical Equipment, Supplies and Appliances not listed as covered services in chapter 14 of the Alabama Medicaid Provider Manual may be requested for coverage by submitting the request to the Long Term Care Division for review and consideration. It will be the provider's responsibility to supply Medicaid with the necessary medical documentation justifying the need for the requested items.

For any additional information regarding coverage of any of the durable medical equipment and supplies listed above, please contact the Long Term Care Division at (334) 293-5504.

Patient 1st on the Web

For your convenience, Patient 1st information on the Medicaid website, www.medicaid.state.al.us, continues to unfold. From the wedsite, you will find answers to most questions you have regarding the Patient 1st Program, as well as, an Alabama Medicaid Product Catalog, the form to change a recipient's PMP; and a form to request recipient education.

From the Site Map on Medicaid's Home Page you may access a library of information, including the following topics relating to Patient 1st:

- Patient 1st Provider List by County
- PMP contact list to help providers contact PMPs – includes current fax numbers
- Checkwrite Schedule for Fiscal Year 2003
- Provider Enrollment Application
- Patient 1st EPSDT Referral Form
- Patient 1st Request Form for Brochures, Posters, & Forms
- Form 349 (new): How to Change Your Patient 1st Personal Doctor
- Form 379 (new): Patient 1st Request For Patient Education
- EDS Contact Information
- Provider Software, Bulletins, and Notices
- Product Catalog (new)
- Provider Manual – including updated Patient 1st Chapter 39, EPSDT Appendix A, and Managed Care Appendix D.
- Patient 1st Provider FAQ and Hand Book
- TIPS Newletters

If you need information not found on the Alabama Medicaid website, please call Kay Hassett, Patient 1st Program Manager at (334) 242-5054 or email her at this address, khassett@medicaid.state.al.us.

Prior Authorization Needed

Effective September 1, 2003, procedure codes L1520 (THKAO, swivel walker), L1300 (other scoliosis procedure, body jacket molded to patient)and L1310 (other scoliosis procedure, post-operative body jacket) will require prior authorization by the Alabama Medicaid Agency. Requests for coverage of these codes must be submitted using Alabama Medicaid's prior approval process. All supporting medical documentation justifying the need for these devices must accompany the prior authorization request.

EDS Provider Representatives

G R O U P 1

North: Stephanie Westhoff, Jenny Homler, Jeanne Caperton, and Marilyn Ellis

Bibb, Blount, Calhoun, Cherokee, Chilton, Clay, Cleburne, Colbert, Coosa, Cullman, DeKalb, Etowah, Fayette, Franklin, Greene, Hale, Jackson, Jefferson, Lamar, Lawrence, Lauderdale, Limestone, Madison, Marion, Marshall, Morgan, Pickens, Randolph, Shelby, St. Clair, Talladega, Tuscaloosa, Walker, Winston

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CRNA
EPSDT (Physicians)
Dental
Physicians
Optometric
(Optometrists and Opticians)

G R O U P 2

Rehabilitation Services
Home Bound Waiver
Therapy Services
(OT, PT, ST)
Children's Specialty Clinics
Prenatal Clinics
Maternity Care
Hearing Services
Mental Health/Mental Retardation
MR/DD Waiver
Ambulance
FQHC

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Public Health
Elderly and Disabled Waiver
Home and Community
Based Services
EPSDT
Family Planning
Prenatal
Preventive Education
Rural Health Clinic
Commission on Aging
DME
Nurse Midwives

G R O U P 3

Ambulatory Surgical Centers
ESWL
Home Health
Hospice
Hospital
Nursing Home

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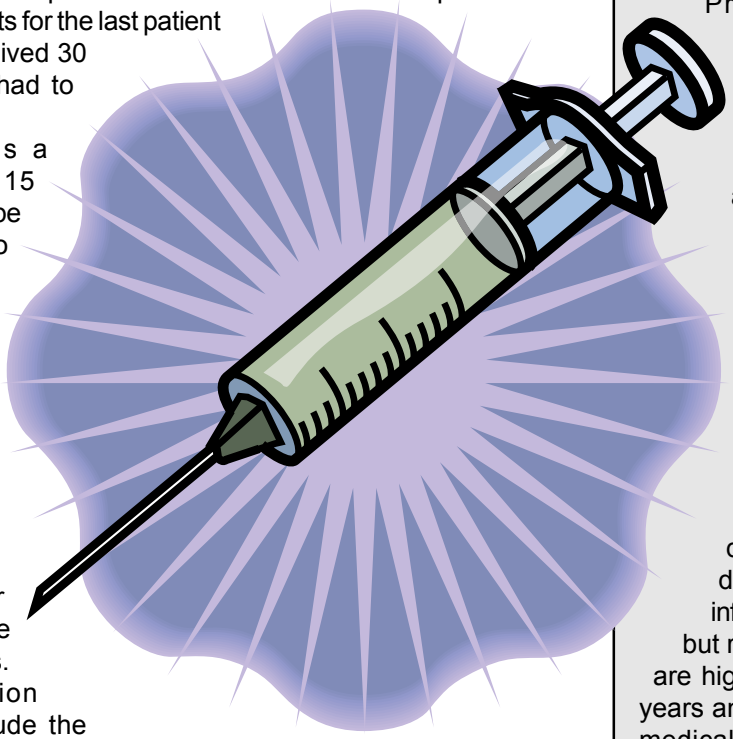
Personal Care Services
PEC
Private Duty Nursing
Renal Dialysis Facilities
Swing Bed

Instructions for Botulinum Toxin Billing

Procedure code J0585 (Botulinum Toxin Type A) reads "per unit" and is currently available only in 100 unit size. Therefore this code requires the units of service on the claim to reflect the number of units used. However, if a physician must discard the remainder of a vial after administering it to a patient, the Agency will cover the amount of the drug discarded along with the amount administered. Because of the expense of the drug, and once it is reconstituted in the physician's office has a shelf life of only four (4) hours, physicians are encouraged to schedule patients in a manner that they can use botulinum toxin most efficiently. For example, a physician schedules three patients requiring botulinum toxin type A on the same day within the designated shelf life of the drug. The physician administers 30 units to all three patients and bills 30 units for the first two patients and 40 units for the last patient. The physician would bill 40 units for the last patient because the patient received 30 units but the physician had to discard 10 units.



Another example is a physician administers 15 units of botulinum toxin type A and it is not practical to schedule another patient who requires botulinum toxin. Situations that are impractical to schedule another patient include (a) it is the first time the physician has seen the patient and did not know the patient's condition or (b) the physician has no other patients who require botulinum toxin injections.

Documentation requirements must include the exact dosage of the drug given and the exact amount of the discarded portion in the patient's medical record as well as the corresponding diagnosis. However, if no benefit is demonstrable by two sets of injections, further injections will not be considered medically necessary.

HCPCS code for J0587 (Botulinum Toxin Type B) reads "per 100 units". Therefore, 100 units of J0587 will equal one billing unit.

Flu Season Is Just Around the Corner

Just a reminder flu vaccination is a covered service for eligible recipients. Procedure codes 90657 (influenza 6-35 months) and 90658 (influenza 3 years and older) are covered for the administration fee through the Vaccines for Children (VFC) program. If you are not enrolled as a VFC provider, please refer recipients to your local County Health Department for flu vaccination.

Procedure code (PC) 90659 (influenza virus vaccine) is a covered service for recipients of any age. Please remind billing staff that if an office visit is billed on the same date as PC 90659, an administration fee may not be billed.

According to Prevention and Control of Influenza: Recommendations of the Advisory Committee on Immunization Practices (ACIP), Vol. 52/RR-8, "Epidemics of influenza typically occur during the winter months and have been responsible for an average of approximately 36,000 deaths/year in the United States during 1990-1999. Rates of infection are highest among children, but rates of serious illness and death are highest among persons aged > 65 years and persons of any age who have medical conditions that place them at increased risk for complications from influenza. The optimal time to receive influenza vaccine continues to be October and November."

Billing Instructions for Unclassified Injectable Drugs

When a provider bills more than one detail for an unclassified drug, the second detail must have a moderfier 76 to designate a separate unclassified drug, and the description of the drug must be indicated on the claim.

DATE(S) OF SERVICE						Place of Service	Type Of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual circumstances)		DIAGNOSIS CODE	$CHARGES	DAYS OR UNITS
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER			
07	01	2003	07	01	2003	11	1	J3490	*Tagamet 300mg*	1	3.22	1
07	01	2003	07	01	2003	11	1	J3490 76	*Pepcid 20mg*	1	8.37	1

State Fiscal Year 2003-2004 Checkwrite Schedule

10/10/03	01/02/04	04/09/04	07/09/04
10/24/03	01/16/04	04/23/04	07/23/04
11/07/03	02/06/04	05/07/04	08/06/04
11/21/03	02/20/04	05/21/04	08/20/04
12/05/03	03/05/04	06/04/04	09/03/04
12/12/03	03/19/04	06/18/04	09/10/04

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Alabama Medicaid Bulletin

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